Supreme Court, U.S.
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No. —OFFICE OF THE CLERK

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1993

VERNON HOME HEALTH CARE AGENCY, INC.,

Petitioner

v.

UNITED STATES OF AMERICA,

Respondent

Petition for Certiorari to the
United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Should Interpretive Administrative Rules Be Denied Retroactive Effect?

II. Is Taking of Property Pursuant to Unpublicized Administrative Rulemaking Inconsistent with the Administrative Procedure Act, Fifth Amendment Due Process and Equity?

III. Is Certiorari Appropriate Because of the Practical Hardship Wrought by This Case Upon Providers and Patients?

IV. Should the *Kimbell Foods* Tests, Rather Than the *De la Cuesta* Tests, Determine Whether Informal Acts of Administrative Discretion Preempt State Rules That Ordinarily Govern Commercial Relationships?

LIST OF ALL PARTIES TO THE PROCEEDING

Name of Person	Relationship
William E. Ball	Shareholder of Parent, Director, Chief Executive Officer, President of Parent and Subsidiary
Charles Gouge	Chief Operating Officer of Parent and Subsidiary
Phillip Hoffman	Chief Financial Officer of Parent and Subsidiary
Mary Lou Ball	Shareholder of Parent, Vice President of Parent and Subsidiary
Rebecca Ball Herd	Secretary and Treasurer of Parent and Subsidiary
Steve Melvin	Assistant Secretary of Parent and Subsidiary
Estate of Bettye J. Wallace	Shareholder of Parent
Sandra Bale	Shareholder of Parent
Outreach Health Care, Inc., a Texas corporation	Parent of Subsidiary

Vernon Home Health Care, Inc., a Texas corporation	Petitioner, Wholly-owned Subsidiary of Parent
Cecil S. Mathis & Associates, P.C., and Cecil S. Mathis	Counsel for Petitioner below
Joe Costello	Defendant below
Gary Chapman	Prior Owner of Vernon Home Health Care, Inc.
John Singer	Expert Witness
John Eury	Employee, Department of Health and Human Services
Julia Kennedy	Department of Health and Human Services
Department of Health and Human Services, Health Care Financing Administration	Respondent, Government Agency
Randi Russell	Assistant United States Attorney
Gayla Fuller	Chief Counsel, Department of Health and Human Services

Joel Lerner	Regional Counsel, Department of Health and Human Services
Charlene M. Seifert	Assistant Regional Counsel, Department of Health and Human Services
Marguerite Lokey	Assistant Regional Counsel, Department of Health and Human Services
Harriman, Jansak, Levy & Wylie, and John Jansak	Counsel for Petitioner
Jack L. B. Gohn	Counsel for Petitioner
Morrie Levy	Expert Witness on Petition
William A. Dombi	Expert Witness on Petition

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I. REPORTS OF OPINIONS

The unreported decision of the United States District Court for the Eastern District of Texas, dated March 2, 1993, is reprinted as Appendix A, at Pages A1 - A2. The ruling of the United States Court of Appeals for the Fifth Circuit, dated June 1, 1994, is reported as **United States v. Vernon Home Health, Inc.**, 21 F.3rd 693, and reprinted as Appendix B at Pages A3 - A9 .

II. JURISDICTION

The ruling of the Fifth Circuit affirming the District Court was issued June 1, 1994. This Court's jurisdiction is invoked pursuant to 28 U.S.C. §1254.

III. CONSTITUTIONAL PROVISIONS, STATUTES, REGULATIONS AND ADMINISTRATIVE RULINGS INVOLVED

UNITED STATES CONSTITUTION, ART. VI, cl. 2

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof ... shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

UNITED STATES CONSTITUTION, AMENDMENT 5

> No person shall ... be deprived of ... property, without due process of law; nor shall private

property be taken for public use, without just compensation....

5 U.S.C. §552 (Administrative Procedure Act)

(a) Each agency shall make available to the public information as follows:

(1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public –...

(D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and

(E) each amendment, revision, or repeal of the foregoing.

Except to the extent that a person has actual and timely notice of the terms thereof, a person may not in any manner be required to resort to, or be adversely affected by, a matter required to be published in the Federal Register and not so published....

(2) Each agency, in accordance with published rules, shall make available for public inspection and copying — ...

(B) those statements of policy and interpretations which have been adopted by the

agency and are not published in the Federal Register....

A ... statement of policy, interpretation, or staff manual or instruction that affects a member of the public may be relied on, used, or cited as precedent by an agency against a party other than an agency only if –

(i) it has been indexed and either made available or published as provided by this paragraph; or

(ii) the party has actual and timely notice of the terms thereof....

5 U.S.C. §553 (Administrative Procedure Act)

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law...

Except when notice or hearing is required by statute, this subsection does not apply –

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice....

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making....

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except – ...

(2) interpretative rules and statements of policy ....

42 U.S.C. §1302(a)

The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act.

42 U.S.C. §1395g(a)

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate ... with necessary adjustment on account of previously made overpayments or underpayments....

Tex. Bus. Corp. Act Art. 5.10 B

A disposition of any, all, or substantially all, of the property and assets of a corporation, whether or not it requires the special authorization of the shareholders of the corporation, effected under

Section A of this Article or under Article 5.09 of this Act or otherwise:

(1) is not considered to be a merger pursuant to this Act or otherwise; and

(2) except as otherwise expressly provided by another statute, does not make the acquiring corporation, foreign corporations, or other entity responsible or liable for any liability or obligation of the selling corporation that the acquiring corporation, foreign corporation, or other entity did not expressly assume.

Texas Uniform Fraudulent Transfer Act, Tex. Bus. & Comm. Code §24.007

(a) A transfer made or obligation incurred by a debtor is fraudulent as to a creditor whose claim arose before the transfer was made or the obligation was incurred if the debtor made the transfer or incurred the obligation without receiving a reasonably equivalent value in exchange for the transfer or obligation and the debtor was insolvent at that time or the debtor because insolvent as a result of the transfer or obligation.

(b) A transfer made by a debtor is fraudulent as to a creditor whose claim arose before the transfer was made if the transfer was made to an insider for an antecedent debtor, the debtor was insolvent at that time, and the insider had reasonable cause to believe that the debtor was insolvent.

Texas Uniform Fraudulent Transfer Act, Tex Bus. & Comm. Code §24.008(a)

(a) In an action for relief against a transfer or obligation under this chapter, a creditor ... may obtain:

(1) avoidance of the transfer or obligation to the extent necessary to satisfy the creditor's claim;

(2) an attachment ...

(3) subject to applicable principles of equity and in accordance with applicable rules of civil procedure:

(A) an injunction against further disposition by the debtor or a transferee, or both, of the asset transferred or of other property;

(B) appointment of a receiver...; or

(c) any other relief the circumstances may require.

42 CFR §401.108 HCFA Rulings

(a) After September 1981, a precedent final opinion or order of a statement of policy or interpretation that has not been published in the FEDERAL REGISTER as a part of a regulation or a notice implementing regulations, but which has been adopted by HCFA as having precedent, may be published in the FEDERAL REGISTER as a

HCFA Ruling and will be made available in the publication entitled *HCFA Rulings.*

(b) Precedent final opinions and orders and statements of policy and interpretation that were adopted by HCFA before October 1981, and that have not been published in the FEDERAL REGISTER are available in *HCFA Rulings.*

(c) HCFA Rulings are publishing under the authority of the Administrator, HCFA. They are binding on all HCFA Components, and on the Social Security Administration to the extent that components of the Social Security Administration adjudicate matters under the jurisdiction of HCFA.

42 CFR §489.18 Change of ownership or leasing: Effect on provider agreement

(a) *What constitutes change of ownership* – .... (3) *Corporation.* The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership....

(c) *Assignment of agreement.* When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date.

(3) Compliance with applicable health and safety standards.

(4) Compliance with the ownership and financial interest disclosure requirements of par 420, subpart C, of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

HCFAR-78-3
SECTION 1866.--PROVIDER-AGREEMENT WITH NURSING HOME--EFFECT OF ASSUMPTION OF TITLE BY TRUSTEE IN BANKRUPTCY

Where a provider is adjudged bankrupt, continuation of the provider's enterprise by a trustee in bankruptcy pursuant to court order, held not in itself such a change in ownership as to require the execution of a new section 1866 agreement, since there is neither the purchase of an ownership interest by the trustee nor a correlative transfer of the intrusted property to a new, non-obligated party.

After approval as an "extended care facility" within the meaning of section 1861(j) of the Social Security Act, and entering into a Provider Agreement for participation in the Medicare program, a nursing home has been adjudged bankrupt and is being operated by a trustee in bankruptcy acting for the creditors under Chapter 10 of the Bankruptcy

Act (Title 11 U.S.C. 501 et seq.). The facility continues to admit medicare patients on the assumption that it will be paid under the provisions of title XVIII of the Social Security Act governing agreements with providers of services. The trustee's administration is authorized by an "Order Approving Petition and Appointing Trustee," issued by the bankruptcy court. This order explicitly provides that the bankrupt provider be operated without interruption and on a continuing basis. In pertinent part it provides as follows:

> 9. That said Trustee is hereby vested with power to administer the said property * * *; to continue to operate, manage and control the business of the debtor as heretofore conducted by the debtor for and indefinite period * * *; to perform existing contracts of the debtor and to enter into and perform other contracts in the regular course of the conduct of the business * * *.

An institution or organization which qualifies as a provider of services under section 1861 of the Act may participate and become eligible for payments under the title XVIII health insurance program if it files an agreement with the Secretary pursuant to section 1866 under the Act. Such agreement, which may be terminated by either party as provided under section 1866(b), also ceases to be effective when the contracting party can no longer be required to abide by its terms (e.g., because of a change in ownership). In view of the trustee's assumption of title to the bankrupt nursing home in the instant case, a question is raised as to whether this terminates the 1866 agreement entered into with the provider, so as to require a new survey and certifi-

cation, title VI clearance, and the conclusion of a new provider agreement.

Where the original contracting provider ceases to exist as a legal entity or as the operating provider, neither the statute nor the section 1866 agreement provides for continuing coverage for Medicare beneficiaries. The reason for this gap in coverage is that the section 1866 Provider Agreement is with a "person" in the legal sense (that is, an individual, a partnership, a corporation or other recognizable entity) and that being personal to the contracting party, it cannot be enforced against another party. The effect of a transfer of ownership of a provider facility is that patients of the facility are not covered under title XVIII unless the facility reapplies, meets the applicable conditions for participation, and concludes a Provider Agreement in accordance with section 1866 of the Act.

However, such is not the situation when there is mere transfer of legal title to a trustee in bankruptcy. In that situation there is neither the purchase of an ownership interest by the trustee nor a correlative transfer of the instrusted property to a "new", non-obligated party. The effect of bankruptcy and the appointment of a trustee of the bankrupt estate has been described as follows:

> The estate of the bankrupt is devolved upon the trustee, subject to the rights of other persons therein. The substance in which those rights inhere is impounded. But * * * it is the same substance, with the same incidents as before. The court takes it into its exclusive dominion and control, and, in harmony with the general principle of law governing the exercise of jurisdiction in

> such cases, it accords to every person who has an interest in the res the privilege of intervening and establishing his rights in the thing which has been seized. * * * The trustee is the hand of the court. He stands as its agent to liquidate the assets, to protect them, and bring them before the court for final distribution. He is not, in fact, more representative of one creditor or claimant than another. The trustee, in the procedure, because he has the legal title to the assets, and is charged with the duty of saving and protecting them, represents the general fund. He is not a purchaser, but as the title of his office imports, he is trustee for all who have interest, and according to those interests. He himself has no interest and there is nothing in his representation which stands between the court and those who have interests, for the recognition and protection of which they appeal to its authority. **In re Ducker**, 134 F. 43 at 46-47 (1905).

There is in the present instance an explicit authorization to continue the operation of the business on the same basis as before. While explicit action (i.e., notice to the Secretary) by the trustee in bankruptcy is needed to terminate the Provider Agreement, he need not formally acknowledge his willingness to continue to be bound by the section 1866 agreement.

Thus, it may be noted that the trustee–having assumed the mutual obligations of the bankrupt–would be deemed to stand in the place of the bankrupt not only with regard to his rights but also as to his obligations under the Provider Agreement. It is accordingly held that the section 1866 Provider-Agreement with the nursing home is not terminat-

ed by reason of the assumption of title thereto by a trustee in bankruptcy who continues to administer and operate the facility pursuant to a court order issued under chapter 10 of the Bankruptcy Act (Title 11, U.S.C. 501 et seq.).

IV. STATEMENT OF THE CASE

Until March 1985, Vernon Home Health, Inc., a Texas non-profit corporation ("Vernon I") received Medicare reimbursement for services it provided. Pursuant to provisions of the Medicare program, Vernon I held a provider agreement ("Provider Agreement") with the Health Care Financing Administration ("HCFA"). One of the Medicare regulations, 42 CFR §489.18 ("the Regulation"), provided that when a "change of ownership" took place, the Provider Agreement would automatically be reassigned, if certain conditions were met.

On March 1, 1985 Vernon I sold its assets in an arm's length transaction to Petitioner Vernon Home Health Care Agency, Inc., a Texas corporation, ("Vernon II"). Vernon I and Vernon II were totally unrelated entities. The terms of sale explicitly transferred only assets, not liabilities. Vernon II did not purchase the stock, an expedient sufficient to protect Vernon II from Vernon I's liabilities under Texas Bus. Corp. Act Art. §5.10 B, and the undisputed proof was that the purchase was not a fraudulent and therefore reversible transfer within the meaning of the Texas Uniform Fraudulent Transfer Act, Tex. Bus. & Comm. Code §§24.001 **et seq.** The sale price was $23,051.96. Because this transfer constituted a "change of ownership" within the meaning of the Regulation, and other conditions were met, the Provider Agreement was formally reassigned in October of 1985.

Before the asset sale, however, in 1984, **Vernon I** had received a notice from HCFA claiming a right to repayment of $30,072.08 in alleged overpayments from HCFA. On May 11, 1992, the United States filed the present action to recover these overpayments[1] from **both Vernon I and Vernon II**, notwithstanding that Vernon II had not been the payee of the funds in question, and had received no actual or constructive notice of the overpayment at the time of the sale of Vernon I's assets. Vernon I admitted the liability, but did not make payment. On March 2, 1993, the United States District Court for the Eastern District of Texas granted the United States' motion for summary judgement against Vernon II. The ruling, App. A, simply recited as its basis that "Plaintiff is entitled to a judgment as a matter of law."

The apparent basis for this judgment was an affidavit of John Eury, Chief of the Payment and Systems Branch of HCFA, to the effect that there existed a long-standing HCFA policy ("the Policy") that when "HCFA is unable to recoup money from the entity that owed the provider at the time during which the overpayment accrued, it is HCFA policy to seek recovery from the entity owning the provider at the time recovery is sought." The affidavit was signed October 9, 1992. HCFA's counsel contended that the Policy constituted an interpretation by HCFA of the Regulation, and that the appropriate standard of review of the Policy was that it should be upheld unless patently unreasonable or arbitrary.

There was no proof that Vernon II had ever received actual or constructive notice of the Policy, which had never

[1] There is no dispute about the amount of the overpayment, only about whether Vernon II is liable.

been reduced to writing in any official way.[2] Nor did HCFA argue or prove that the Policy was self-evident on the face of either the statute under which HCFA made its claim, 42 U.S.C. §1395g(a) ("the Statute"), or the Regulation. Though challenged to provide proof that the Policy had been publicized in some fashion, HCFA never responded. To the contrary, Vernon II produced affirmative proof that the wide-spread understanding of the health care industry was that no such Policy existed.

This judgment was appealed to the United States Court of Appeals for the Fifth Circuit. Before the Fifth Circuit, Vernon II argued, **inter alia**, that the confiscation of Vernon II's property on the basis of an unpublicized policy violated the Fifth Amendment of the United States Constitution, and equity. HCFA countered that whatever Vernon II's expectations of freedom from liability for Vernon I's obligations under Texas law, the Policy preempted Texas law.

On June 1, 1994, the Court of Appeals issued its ruling. App. B. There the Court made no reference whatsoever to Vernon II's Fifth Amendment arguments, even though it acknowledged that "Vernon II agreed (**albeit unknowingly**) to accept the terms and conditions of the regulatory scheme." App. at 9. [**Emphasis added.**] Instead, the Court indulged in a legal analysis that could in no way be reconciled with the Court's just-noted factual conclusion that Vernon had had no way of knowing that the Regulation

[2] HCFA did cite, and the Fifth Circuit later relied upon **Beverly Enters. v. Califano**, 460 F.Supp. 830 (D.D.C. 1978), but that case had to do with the liability of a stock purchaser, not an asset purchaser. As is discussed below, the Statute and the Regulation might have given some notice of this supposed interpretation to a stock purchaser, but not to an asset purchaser.

meant HCFA could recoup from assignees. The Court suggested that the Regulation "unambiguously" permitted HCFA to recoup from assignees, and that the Regulation was issued within HCFA's authority. App. at 7. The Court found this lack of ambiguity in the Regulation on the basis of the language therein that a party accepting assignment of a provider agreement agreed to accept the "terms and conditions" of the provider agreement in the assignor's hands. Given that, in the Court's view, the Statute made recoupment of overpayment one of the "terms and conditions" of a provider agreement, an assignee accepted liability for recoupment along with the benefits of the provider agreement. As to preemption, the Court held that, since Social Security is a national federal program, the Statute and Regulation, as interpreted by the Policy, must preempt Texas law. Accordingly, the Fifth Circuit affirmed.

This Petition has been timely filed.

V. REASONS FOR GRANTING THE WRIT

A. Summary

Certiorari is warranted for the following reasons:

1. **Circuit split on the retroactive effect of interpretive rulemaking.** With this ruling, the Fifth Circuit has allowed a HCFA interpretive rule to have retroactive effect. At nearly the same time, the D.C. Circuit has refused to do so. This important dispute needs to be resolved.

2. **Need to repudiate the use of unpublished informal rulemaking against those without notice.** The

Policy, reversing a published agency ruling and inconsistent with the understanding of the health care industry, was implemented without notice to the industry. Given that there was a way to avoid the adverse effects of the Policy, it was incumbent on HCFA to notify the industry concerning the Policy and how to avoid adverse effects, and not to apply the Policy to those who had acted in ignorance of it. Both the Administrative Procedure Act ("the APA") and HCFA's regulations would appear to have required publication of the Policy. Certiorari is appropriate to clarify what the APA, Due Process and equity require in the way of notice of informal policy-making.

3. **Wide adverse impact of lower courts' rulings.** The lower courts' rulings will wreak a severe practical hardship in the highly regulated hospital and home health care industry, adversely affecting both health care providers and patients. They also promise, as a near certainty, to result in industry behavior contrary to Congressional and administrative objectives.

4. **Preemption test chosen threatens commercial relationships ordinarily governed by state law.** The Fifth Circuit relied on the highly deferential preemption test in **Fidelity Fed. Sav. & Loan Ass'n v. De la Cuesta**, 458 U.S. 141 (1982) rather than the more stringent analysis seemingly required by **United States v. Kimbell Foods, Inc.**, 440 U.S. 715 (1979) for exercises of administrative discretion like those here. This case poses the important question whether **Fidelity Federal** has silently overruled **Kimbell Foods** in all cases where preemption is urged on the basis of any administrative interpretation of a statute.

Vernon II now takes up these issues in detail.

B. Interpretive Rules Should Not Be Given Retroactive Effect.

This case clearly pits the Fifth Circuit against at least the D.C. Circuit on the question whether interpretive rules should be given retroactive effect. (That effect is already precluded as to "legislative rules" by **Bowen v. Georgetown Univ. Hosp.**, 488 U.S. 204 (1988).)

That the Policy, as enunciated in the Eury affidavit, was what is known as an "interpretive rule" cannot be doubted. It interpreted the Regulation and the Statute, which on their face do not suggest that provider agreement assignees are subject to recoupment. In fact, as will be demonstrated in the next section, a fair reading of the Statute leaves no doubt that Congress intended that provider agreement assignees **not** be subject to recoupment. By allowing recoupment from Vernon II, the Fifth Circuit was therefore applying the Policy, and not applying what the Statute or the Rule say on their face.[3]

There is also no doubt that this constituted a retroactive effect for the Policy. Though HCFA neglected to mention this either to Vernon II or to the courts below, **HCFA itself** was on public record as interpreting the

[3] While it is true that the Fifth Circuit seemed to suggest that the Regulation "unambiguously" subjects provider agreement assignees to recoupment, the Court also stated that Vernon II "unknowingly" subjected itself to recoupment. These two propositions cannot be reconciled. If the Regulation were truly unambiguous, Vernon II would have had at least constructive notice of its peril, and the Fifth Circuit surely would have noted this. Accordingly, it must be concluded that the Fifth Circuit was in fact giving effect to the Policy **as such**, whether or not it acknowledged so doing.

Statute in precisely the opposite fashion from the Policy. On January 1, 1978, HCFA had issued a formal Ruling, HCFAR-78-3 ("the Ruling"), which stated that a provider agreement, "being personal to the contracting party, ... **cannot be enforced against another party.**" Reprinted at Page 10, **supra**. HCFA also twice referred to the kind of transaction involved here as a "transfer of the ... property to a new, **non-obligated party.**" **[Emphases added.]** Reprinted at Pages 8, 10, **supra**. And unlike the Policy, the Ruling was "binding" on HCFA by force of HCFA's own regulations. 42 CFR §401.108(c). While it is true that the Regulation was published after the Ruling, agency comments accompanying promulgation of the Regulation made it plain that the Regulation was passed only to assure continuous coverage to Medicare beneficiaries when a change of ownership occurred. There was no intent to alter the law or practice regarding recoupment or to revoke the Ruling.[4] Hence the Ruling remained in apparent force up

[4] The regulation was first proposed in 44 Fed.Reg. 25 (Feb. 5, 1979), at 6958 **et seq.**, and published in final form in 45 Fed.Reg. 67 (Apr. 4, 1980) at 22933 **et seq.** Comments set forth in both places made it clear what the regulation was and was not intended to accomplish. As the first proposal stated: "The intent is to simplify administration and prevent unnecessary interruption of benefits to nursing home patients." 44 Fed.Reg. at 6958. The final publication stated: "The intent of the substantive changes is to achieve maximum uniformity of policy for [Medicare and Medicaid] and to provide continuity of coverage for beneficiaries and recipients when there is a change of ownership." 45 Fed.Reg. at 22933. This was followed by an invitation to "anyone who believes that we have made policy changes other than those described in the preamble" to notify HCFA, presumably to enable HCFA to amend the regulation to reverse any

(continued...)

to the moment Vernon II was served with the complaint in this action.

Although the record is devoid of any evidence at what point HCFA formulated the Policy, HCFA obviously never published it. Other unknown asset transferees may have learned of it through HCFA's collection efforts, as did Vernon II. However, it must be concluded that, as to Vernon II, the Policy took effect either the day Vernon II was sued or the day Mr. Eury signed his affidavit. Both events occurred in 1992. Obviously, the assets transfer occurred years before that day. Thus, when the courts below allowed HCFA to collect from Vernon II, they were giving the unwritten Policy retroactive effect.

In that regard, the Fifth Circuit put itself in clear conflict with the District of Columbia Circuit, which less than a month before the decision in this case had held that interpretive regulations of HCFA cannot be made retroactive when the effect is to recoup money from health providers who had relied upon a previous policy. In **Health Ins. Ass'n of America, Inc. v. Shalala**, ___ F.3d ___, Medicare & Medicaid Guide (CCH) ¶42,264 at 40,163 (D.C.Cir. 1994), the D.C. Circuit was presented with the issue whether a series of HCFA interpretive regulations formally issued in 1989 could be applied to reverse a number of provider payments issued before the regulations became effective. The D.C. Circuit held that HCFA was free to argue that the relevant Medicare statutes had always meant what they meant before the 1989 regulations, but not

[4](...continued)
additional change. Clearly, there was no explicit or implicit intent to alter what had been enunciated agency policy regarding the non-obligation of asset purchasers to refund HCFA overpayments to asset sellers.

free to cite the regulations to the court as evidence of what the statutes had meant before that date. In other words, the interpretive regulations lacked retroactive force.

In effect, the Fifth Circuit gave Mr. Eury's affidavit announcing the interpretive Policy retroactive force, since, as the Fifth Circuit noted, Vernon II had to act "unknowingly" with respect to that Policy. Hence the Fifth and District of Columbia Circuits are in conflict.

The issue on which they conflict, whether an informal interpretive rule can have retroactive effect, is an important issue of administrative law, and one that clearly needs to be resolved. This Court should grant certiorari to do so.

C. Taking of Property Pursuant to Unpublicized Rulemaking Is Inconsistent with the Administrative Procedure Act, Fifth Amendment Due Process and Equity.

A closely related but analytically distinct problem is raised by the covert (whether or not intentionally so) nature of the governmental policymaking here.[5] When an agency attempts to take property under a policy it has never publicized, this raises problems under the APA, Due Process and equity. As HCFA itself argued, and the Fifth Circuit agreed, Vernon II could have avoided recoupment by not agreeing to automatic assignment of the Provider Agreement and the provider number. It is a certainty that,

[5] The problem is distinct because rules and regulations that an agency seeks to make retroactive may be published and promulgated with APA notice, comment and/or deliberation, pursuant to 5 U.S.C. §553. For instance, in the **Health Ins. Ass'n** case, cited in the previous section, HCFA accorded full APA publicity to the rules there in dispute.

had Vernon II known of the threat of recoupment, it would have declined the automatic assignment, even though (as will be discussed in the next section) this would have caused considerable inconvenience for Vernon II and might have meant undue financial burdens for Vernon II's patients (effects which, if this ruling stands, will be duplicated throughout the industry). But HCFA's chosen course of informal policymaking obviated Vernon II learning of the threat.

Case law indicates that where the written law "on the books" suggests a meaning consistent with an agency's interpretation, the fact that a member of the public is unaware of the agency's interpretation will not keep the written law from applying, consistent with the unpublished interpretation, against that individual. But this case suggests that a corollary needs to be authoritatively stated: that where the that agency interpretation is in fact the only place from which a member of the public could have learned that the there existed a threat of adverse agency action, the agency must place that individual on notice before he acts so as to subject himself to such action.

As the Fifth Circuit noted, the Regulation simply subjects the assignee of a provider agreement to "the terms and conditions" under which the original agreement was issued. Recoupment from an assignee is not specifically mentioned in the Regulation. As HCFA contended, and as the Fifth Circuit agreed, this particular "term and condition" is only to be found in the text of the Statute. The only problem with the analysis is that the Statute clearly indicates that recoupment is not permitted from an assignee.

The Statute reads in relevant part:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate ... with necessary adjustment on account of previously made overpayments or underpayments....

[**Emphasis added.**] The emphasized language (which the Fifth Circuit elided when it reprinted the passage) makes clear that for each "provider," the "overpayments" which are to be "adjusted" are those which relate to "services furnished by it," and not by some other provider.[6] Since the Statute does not contemplate HCFA "adjusting" by recouping overpayment from someone other than the overpaid provider, a recoupment from someone other than the overpaid provider is not one of the "terms and conditions" of the provider agreement. It follows that the provision in the Regulation that the "terms and conditions" of a provider agreement bind the assignee does **not** suggest that an assignee (other than a true corporate successor) is subject to recoupment.

Not only did the Statute and Regulation provide no forewarning of the Policy, but HCFA's published Ruling, its only public word on the subject, would, if known to Vernon II, have further lulled it into a false sense of security. Of course, if HCFA, in arriving at the Policy,

[6] This distinguishes the **Beverly** case discussed in Note 2, **supra**, from the present situation. The provider corporation there had not changed, although its stock had changed hands. This did not constitute a "change of ownership" within the meaning of the Regulation.

had engaged in formal APA-style rulemaking, that would have served to alert Vernon II or at least to place it on constructive notice. But HCFA did no such thing.

It is not as if HCFA was unable to publish its change of mind embodied in the Policy; in fact both the APA and HCFA's own regulations seem to have required this before the Policy could have been applied adversely to Vernon II. Under the APA, 5 U.S.C. §552(a), HCFA was required to find some way of making available to the public those "statements of policy and interpretations which have been adopted by the agency and are not published in the Federal Register." And that subsection further provides that a policy "may be relied on, used, or cited as precedent by an agency against a party other than [the] agency" only if published or the party has "actual and timely notice." And 42 U.S.C. §1302(a) requires publication of HCFA's "rules and regulations." Not only does such a proceeding offend the APA, but also, for obvious reasons, Due Process and equity.

The rule that parties are presumed to know the law should have its limits; the public should not be required to read the agency's mind. **See Sisson v. United States**, 630 F.Supp. 1026 (D.Ariz. 1986) (where Army regulation did not seem to proscribe sales solicitation, unpublished and unpublicized Army interpretation holding that the regulation did in fact forbid such conduct could not be used to penalize soldier). This is essentially a part of the "void for vagueness" doctrine. As has long been recognized, where an administrative rule or standard is "so vague and indefinite as to be no rule or standard at all," it cannot serve as the basis for government action against a regulated party. **A.B. Small Co. v. American Sugar Refining Co.**, 267 U.S. 233, 239 (1925). The basis for this principle is that if a member of the public lacks notice of the law, he cannot

alter his behavior so as to avoid undesired consequences. **Connally v. General Const. Co.**, 369 U.S. 385, 391 (1926). And here, as both HCFA and the Fifth Circuit pointed out, there was an alteration of behavior that would have been effective to avoid those consequences – only Vernon II had no way of knowing it.

If this ruling is not reviewed, it may reasonably be expected that other agencies will be encouraged to place members of the public in Kafkaesque situations where they are subject to confiscations for failure to take account of legal interpretations no one has revealed or will reveal to them, in violation alike of Due Process, the APA, and plain equity.

D. Certiorari Is Appropriate Because of the Practical Hardship Wrought by This Case to Providers and Patients.

The lower courts' rulings would cause a severe practical hardship in the highly regulated hospital and home health care industry, adversely affecting both health care providers and patients. The Fifth Circuit commented:

> Vernon II could have chosen not to accept the automatic assignment of the provider agreement. Indeed, the government acknowledges that the case would be different if Vernon II had not assumed Vernon I's provider number.

App. at 8. Though this sounds on its face like a reasonable alternative to the result here (which HCFA in its briefs called "taking the bitter with the sweet") it imposes a Hobson's choice on the home health care and hospital industries and will frustrate HCFA's own objectives.

Vernon II has lodged with this Court the affidavits of William A. Dombi, Director of the Center for Health Care Law, a service of the National Association for Home Care, and of Morrie Levy, Vice President for National Regulatory Affairs of ABC Home Health Services, Inc. As these affidavits show, automatic assignment of provider agreements, coupled with assets-only purchases to protect against the seller's liabilities, including, until now, liability for overpayment of Medicare reimbursements, has been a way of life in the health industry.

If the protection against overpayment liability is impaired by this case, automatic assignments will promptly become a thing of the past. As the Fifth Circuit itself noted and Messrs. Dombi and Levy also aver, Medicare payments are reimbursed on an estimated cost basis subject to year-end accounting. Because payments are on an estimated basis, the final amount will not be ascertained until after the last cost report period has been settled. And Mr. Levy's affidavit shows that it is typical that final settlement occurs two years after the original reimbursement – and hence could occur two years after an asset sale and reassignment of a provider agreement. In other words, any provider accepting an assigned provider agreement can find itself subjected to unknown liabilities two years after the fact. Given the kind of money involved (in this case, around 150% of the purchase price), no sane provider would subject itself to such incalculable liability. The practice of accepting reassignment of provider agreements will not survive this decision, unless it is overruled.

But the consequences to providers and patients of this change of industry practice will be adverse and wide-spread. As the Dombi and Levy affidavits make plain, when a new provider applies for a new provider agreement, the old agreement is ended, and there is an actual break in Medicare

coverage for current patients. During the day or so of interruption, the provider must either seek payment from its patients for the services it renders or take the loss itself. Given the scale of the industry (100,000,000 home health agency visits per year; 6,000 to 7,500 home health agencies in the Medicare program; 11,000 Medicare-certified nursing homes; about 5,800 hospitals), it is a certainty that a great many health providers and a far greater number of patients will be affected in this way each year.

This effect was precisely what HCFA stated it wished to forestall when it instituted the program that permitted assignment of provider agreements. See Note 4, above, for a summary of HCFA's stated rationale.

It follows that the result in this case, as well as the principles at issue, is of great enough importance to warrant certiorari.

E. The *Kimbell Foods* Tests, Not the *De la Cuesta* Tests, Should Determine Whether Informal Acts of Administrative Discretion Preempt State Rules That Ordinarily Govern Commercial Relationships.

This case also sits atop a fault line in the law of preemption. On the one side lie **Fidelity Fed. Sav. & Loan Ass'n v. De la Cuesta**, 458 U.S. 141 (1982) and its progeny, which seem to suggest that in determining whether a given administrative interpretive rule preempts conflicting state law, review is limited to answering the question whether the administrator has exceeded his authority or acted arbitrarily. 458 U.S. at 154. On the other lie **United States v. Kimbell Foods, Inc.**, 440 U.S. 715 (1979) and its progeny, which suggest a far more extensive process of review for the situation where a federal regulatory program

seeks to preempt state law. According to **Kimbell Foods**, the review consists of weighing the need for a nationally uniform body of law, determining whether the application of state law would frustrate specific objectives of the federal program, and considering the extent to which application of a federal rule would disrupt commercial relationships predicated on state law. The two lines of cases could, superficially, be distinguished because **De la Cuesta** deals with regulations, while **Kimbell Foods**' language relates only to the statutory level of programs.

But in fact both cases have to do with exercises of agency discretion in the implementation of a federal program. In **De La Cuesta**, that exercise was through the promulgation of a written regulation; in **Kimbell Foods**, the exercise was through the agency's attempted establishment of an unpublished informal policy of recouping agency funds by voiding state laws protecting competing creditors. The **Kimbell Foods** scenario was therefore essentially identical to the facts here, both in the informal nature of the administrative decision and in the content of the decision.[7] The one case known to undersigned counsel which had previously considered which of these two tests to apply to informal administrative decisions had concluded that **Kimbell Foods** was the proper criterion. **Chicago Title Ins. Co. v. Sherred Village Associates**, 708 F.2d 804 (1st Cir. 1983). The First Circuit's rationale in that case is directly applicable to these facts:

[7] **De la Cuesta** dealt with a written regulation concerning "due on sale" clauses in home mortgages, as to which the government had no direct fiscal interest, as it did in this case and in **Kimbell Foods**.

> We agree that an agency's interpretation of its own regulations is entitled to considerable weight. We also agree that, assuming that the action would be within its delegated authority, the agency could promulgate regulations requiring the "first in time" priority rule. **See Fidelity Federal Savings and Loan Association v. de la Cuesta** .... We are not persuaded, however, that the sum of these two propositions means that an agency may, by its interpretation of its regulations, accomplish a preemption of state law not otherwise supportable in the regulations themselves. Absent a clearer declaration by Congress or HUD, we find that agency's assumption that a federal rule of priority was necessary to ensure its "first lien" statutes an insufficient indication of congressional intent to render **Kimbell Foods** inapplicable.

708 F.2d at 808.

The Fifth Circuit was certainly aware of **Kimbell Foods**, as it cited the case for a different proposition. Yet the Fifth Circuit, splitting from the First Circuit, followed the highly deferential **De La Cuesta** analysis in determining whether preemption should occur. And it seems inconceivable that, on the more stringent **Kimbell Foods** analysis,

the result in this case would have been the same.[8] In other words, the choice of test determined the result.

Hence this case presents in stark form the question whether **Kimbell Foods**' protection for commercial relationships predicated on state law is or is not truly overridden by **De la Cuesta**. If not, the matter should be clarified. The toll continued confusion can wreak should be evident.

VI. CONCLUSION

For all these reasons, this Court should grant certiorari to consider the presented questions.

[8] Under **Kimbell Foods**, it is clear that mere diminished opportunities for governmental recoupment do not constitute a case either for the necessity of a uniform federal rule of decision or for the frustration of federal objectives sufficient to override state law. Meanwhile, as **Kimbell Foods** points out, "in structuring financial transactions, businessmen depend on state commercial law to provide the stability essential for reliable evaluation of the risks involved." 440 U.S. at 739. Absent the need for a nationally uniform body of law, **Kimbell Foods** held that "the prudent course" was not to allow administrative discretion to preempt state law. Given that, as shown by the discussion in the previous section of this Petition, businesspersons in the position of Vernon II's management need to be able to evaluate risks reliably, and this can never occur if the Policy prevails, a **Kimbell Foods** analysis would obviously not favor preemption in the present circumstances.

Respectfully submitted

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Appendix A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. VERNON HOME HEALTH, INC., VERNON HOME HEALTH CARE AGENCY, INC., RESIDENTIAL HEALTH CARE SERVICES, INC. D/B/A ALTERNACARE HOME HEALTH CARE AGENCY, AND JOE COSTELLO, Defendants.	)	Civil No. 6:92CV275

JUDGMENT

This cause came on to be heard on the motion of plaintiff, United States of America, for a summary judgment as authorized by Rule 56 of the Federal Rules of Civil Procedure, and it appearing to the court from the affidavit supporting plaintiff's Motion for Summary Judgment, and from the pleadings that there is no genuine issue as to any material fact and that plaintiff is entitled to a judgment as a matter of law;

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED that summary judgment be entered, and it is hereby entered in favor of plaintiff, United States of America and against defendant, Vernon Home Health Care

Agency, Inc., jointly and severally with Vernon Home Health, Inc. for the principal sum of $30,072.08, plus accrued interest from May 12, 1986 on the principal at 8.0% per annum until the date of judgment, with post-judgment interest on the combined amount of principal and accrued interest at the legal rate of 3.45% per annum compounded annually, until paid, and the United States is authorized to recover a surcharge of ten percent (10%) of the amount of the debt, all for which let execution issue.

SIGNED this 2nd day of March, 1992.

ROBERT M. PARKER
UNITED STATES DISTRICT JUDGE

Appendix B

UNITED STATES of America,
Plaintiff-Appellee

v.

VERNON HOME HEALTH, INC., et al., Defendants,

Vernon Home Health Care Agency, Inc.,
Defendant-Appellant.

No. 93-4621.

United States Court of Appeals,
Fifth Circuit.

June 1, 1994

Appeal from the United States District Court for the Eastern District of Texas.

Before KING and SMITH, Circuit Judges, and KAZEN,* District Judge.

* District Judge of the Southern District of Texas, sitting by designation.

JERRY E. SMITH, Circuit Judge:

Vernon Home Health Care Agency, Inc. ("Vernon II") a purchaser of the corporate assets of a medicare provider, Vernon Home Health, Inc. ("Vernon I"), appeals a summa-

ry judgment in favor of the government for repayment of medicare overpayments made to Vernon I. Finding that the Social Security Act and federal regulations preempt state corporate law in this regard, we affirm.

I.

In March 1985, Vernon I, a Texas non-profit corporation, sold its assets to Vernon II, a Texas corporation. Under the terms of the purchase agreement, Vernon II paid $23,051.96 for the assets of Vernon I and assumed no liabilities.

Vernon II provides home health care to Medicare patients. Pursuant to the provisions of Medicare, a provider number is assigned to each participant in the Medicare programs. Vernon I held Provider No. 45-7124, which was automatically transferred to Vernon II in October 1985.

The government filed a civil action in federal court alleging Medicare overpayments to Vernon I in the amount of $30, 072.08 for the fiscal year ending June 30, 1984. The district court granted summary judgment, finding Vernon II jointly and severally liable with Vernon I for the overpayments.

II.

A.

We review a grant of summary judgment de novo. **Hanks v. Transcontinental Gas Pipe Line Corp.**, 953 F.2d 996, 997 (5th Cir. 1992). Summary judgment is appropriate "if the pleadings, deposition, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and

that the moving party is entitled to a judgment as a matter of law." FED.R.CIV.P. 56(c). The party seeking summary judgment carries the burden of demonstrating that there is an absence of evidence to support the non-moving party's case. **Celotex Corp. v. Catrett**, 477 U.S. 317, 325, 106 S.Ct. 2548, 2554, 91 LEd.2d 265 (1986). After a proper motion for summary judgment is made, the non-movant must set forth specific facts showing that there is a genuine issue for trial. **Hanks**, 953 F.2d at 997.

We begin our determination by consulting the applicable substantive law to determine what facts and issues are material. **King v. Chide**, 974 F.2d 653, 655-56 (5th Cir. 1992). We then review the evidence relating to those issues, viewing the facts and inferences in the light most favorable to the non-movant. **Id.** If the non-movant sets forth specific facts in support of allegations essential to his claim, a genuine issue is presented. **Celotex**, 477 U.S. at 327, 106 S.Ct. at 2555.

Both the government and Vernon II filed affidavits of expert witnesses. John Singer, Vernon II's expert witness, stated that he did not know of any policy that would obligate the purchaser of assets of a provider for overpayments made to the prior provider. He claimed that representatives of Health Care and Financing Administration had made statements to him that such a policy would seriously disrupt health care services.[1] John Eury, the

[1] Because we conclude that the interpretation of the statute and regulations is a legal issue that we must resolve at this stage, we do not reach the issue of whether the affidavit violates FED.R.CIV.P. 56(e), requiring affidavits to be made "on personal knowledge" and not on what the affiant "heard" from someone else. **See Leonard v. Dixie Well Serv. & Supply**, 828 F.2d 291, 295 (5th Cir. 1987).

government's expert, claimed in his affidavit that the purchaser of assets does become liable for overpayments made to the prior provider.

Vernon II claims that these conflicting affidavits create a genuine issue of material fact that cannot be resolved on summary judgment. We disagree. The affidavits express opinions about legal issues that we must resolve **de novo**. **International Ass'n of Machinists & Aerospace Workers v. Texas Steel Co.**, 538 F.2d 1116, 1119 (5th Cir. 1976), **cert. denied**, 429 U.S. 1095, 97 S.Ct. 1110, 51 L.Ed.2d 542 (1977).

B.

Vernon II argues that the purchaser of corporate assets does not assume any liabilities under Texas corporate law because the imposition of liability would amount to a prohibited **de facto** merger. **See Mudgett v. Paxson Mach. Co.**, 709 S.W.2d 755, 758 (Tex.App.–Corpus Christi 1986, writ ref'd n.r.e.). And as Vernon II paid Vernon I a reasonable value for the assets, the sale is not subject to attack as a fraudulent transfer. TEX.BUS. & COM.CODE ANN. ch.24. Thus, Vernon II concludes that the government is not entitled to recover against Vernon II for the overpayments.

Regardless of the result under state corporate law, federal law governs cases involving the rights of the United States arising under a nationwide federal program such as the Social Security Act. **United States v. Jon-T Chems.**, 768 F.2d 686, 690 n. 6 (5th Cir. 1985) (citing **United States v. Kimbell Foods**, 440 U.S. 715, 99 S.Ct. 1448, 59 L.Ed.2d 71 (1971), **cert. denied**, 475 U.S. 1014, 106 S.Ct. 1194, 89 L.Ed.2d 309 (1986)). The authority of the United States in relation to funds disbursed and the rights acquired by it in

relation to those funds are not dependent upon state law. **Kimbell Foods**, 440 U.S. at 726, 99 S.Ct. at 1457. Moreover, when a dispute involves the validity of an agency action, the preemptive force of the action does not depend upon express congressional authorization to displace state law. **NCNB Texas Nat'l Bank v. Cowden**, 895 F.2d 1488, 1494 (5th Cir. 1990). Instead, if Congress has authorized an administrator to exercise his discretion, judicial review is limited to determining whether the administrator has exceeded his authority or acted arbitrarily. **Fidelity Fed. Sav. & Loan Ass'n v. De la Cuesta**, 458 U.S. 141, 154, 102 S.Ct. 3014, 73 L.Ed.2d 664 (1982). **See First Gibraltar Bank, FSB v. Morales**, 19 F.3d 1032 (5th Cir. 1994). Similarly, when the administrator promulgates regulations that preempt state law, the court's inquiry is limited to whether the regulations are reasonable, authorized, and consistent with the statute. **Id.**

The regulations were promulgated pursuant to the Social Security Act, and there is no question that they preempt state law in this area. Thus, the only question is whether the regulations unambiguously require the purchaser of a provider agreement to assume liability for Medicare overpayments made to the prior provider.

C.

The controlling regulation is Title 42 C.F.R. § 489.18(d) which requires: "An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which is was originally issued...." Thus, any purchase of assets that involves the assignment of the provider agreement is subject to the relevant statutory and regulatory conditions. One of these conditions is that adjustments are made for overpayments,

pursuant to 42 U.S.C. § 1395g(a): "The Secretary shall periodically determine ... necessary adjustments on account of previously made overpayments...." **See Beverly Enters. v. Califano**, 460 F.Supp. 830 (D.D.C. 1978) (holding purchaser of stock of corporate owners of nursing home liable for medicare overpayments to corporation); **see also In re Metro Hosp.**, 131 B.R. 283, 291 (E.D. Pa. 1991) (holding that the Secretary's right to offset overpayments is mandated by 42 U.S.C. § 1395g, which serves as a limitation on the assignment in bankruptcy of the provider payments).

We also note that the Secretary's interpretation of the regulation and statute is eminently reasonable. By encompassing a system of interim payments on an estimated cost basis, subject to year-end accounting, the program ensures Medicare providers a steady flow of income sufficient to provide service. The assignee of a provider number is subject to this accounting procedure in order to provide continuous service.

The operative effect of section 498.18(d) is that all assigned provider agreements are subject to the rules and regulations of the Social Security Act. Thus, the state corporate law provisions recognizing Vernon II's right to purchase only assets is preempted by the federal law mandating that all assignments of provider agreements be subject to federal terms and conditions.

Vernon II could have chosen not to accept the automatic assignment of the provider agreement. Indeed, the government acknowledges that the case would be different if Vernon II had not assumed Vernon I's provider number. In that case, Vernon II would have had to apply as a new applicant to participate in the Medicare program. But Vernon II accepted the automatic assignment because it did not want a break in service while it awaited approval.

Provider No. 45-7124 was automatically assigned to Vernon II pursuant to 42 U.S.C. § 1395cc. By accepting that assignment, Vernon II agreed (albeit unknowingly) to accept the terms and conditions of the regulatory scheme. Thus, it is liable for the overpayments.

AFFIRMED.

No. 94-368

FILED
NOV 2 1994
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1994

VERNON HOME HEALTH CARE AGENCY, INC.,
PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether a Medicare provider that has accepted assignment of a provider agreement with the Secretary of Health and Human Services as part of a purchase of the assets of a former provider may be held responsible for overpayments made to the former provider under that agreement.

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In the Supreme Court of the United States

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VERNON HOME HEALTH CARE AGENCY, INC.,
PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The decision of the court of appeals (Pet. App. 3a-9a) is reported at 21 F.3d 693. The decision of the district court (Pet. App. 1-2) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 1, 1994. A petition for a writ of certiorari was filed on August 29, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioner provides home health care to Medicare patients. Pet. App. 4. In 1985, petitioner purchased the assets of Vernon Home Health, Inc. (Vernon I), for approximately $23,000. The purchase agreement provided that petitioner would not assume the liabilities of Vernon I. At petitioner's election (see *id.* at 8), Vernon I's Medicare provider agreement and unique provider number were automatically transferred to petitioner. *Ibid.*

In 1984, before the sale of assets, the Secretary of Health and Human Services had notified Vernon I of an overpayment of approximately $30,000 for the fiscal year ended June 30, 1994, and requested repayment of that amount. Pet. 13; Pet. App. 4. Some time after the asset sale, the government filed this action to recover the overpayment, naming both Vernon I and petitioner as defendants. Both petitioner and the government filed affidavits in the district court addressing whether the purchaser of a provider's assets is obligated to repay Medicare overpayments received by the seller before the sale. Pet. App. 5-6. After concluding that the case presented no issues of fact for trial, the district court granted summary judgment in favor of the government. *Id.* at 1-2.

The court of appeals affirmed. Pet. App. 3-9. The court rejected petitioner's contention that the affidavits filed in the district court created an issue of fact, concluding instead that they addressed a legal dispute to be resolved by the district court in the first instance and reviewed by the appellate court *de novo*. *Id.* at 6.

On the merits, the court turned aside (Pet. App. 6-8) petitioner's argument that recovery was barred by state law principles permitting the sale of assets without the

assumption of liabilities. The court reasoned (*id.* at 6-7) that federal rules governing the disbursement and recoupment of funds under a federal benefits program would preempt any contrary provision of state law. In this case, the court looked to 42 C.F.R. 489.18(d), which specifies that a Medicare provider agreement that is assigned to the purchaser of a former provider's assets "is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued." The court pointed out (Pet. App. 7-8) that the "statutory and regulatory conditions" governing provider agreements include adjustments for, and recoupment of, overpayments. Thus, the court concluded (*id.* at 8-9) that the federal scheme "unambiguously require[s] the purchaser of a provider agreement to assume liability for Medicare overpayments made to the prior provider," and that that requirement preempts any contrary state law. *Id.* at 7-8.

The court further remarked (Pet. App. 8) that the Secretary's interpretation of the statute and regulations was "eminently reasonable." The system of interim payments made on the basis of estimated costs, subject to a year-end accounting and the recoupment of any overpayments, "ensures Medicare providers a steady flow of income sufficient to provide service"; and subjecting the assignee of a provider agreement to the same system generally serves to facilitate continuous service to Medicare beneficiaries. *Ibid.* In this case, the court noted, petitioner could have declined automatic assignment of the provider agreement and chosen instead to apply as a new participant, in which case it would have assumed no liability for overpayments under the old agreement. Petitioner chose, however, to accept the benefits of the assignment. The court concluded that petitioner had thereby submitted to the terms and

conditions of the regulatory scheme, including recoupment. *Id.* at 8-9.

ARGUMENT

1. Petitioner contends (*e.g.*, Pet 13, 15-16, 20) that the government's position in this recoupment action—that petitioner is liable for overpayments made to a previous provider under a provider agreement that petitioner voluntarily assumed—rests on a new "interpretive rule" adopted by the Secretary without fair notice to petitioner. That contention mischaracterizes the government's action and ignores the reasoning of the court of appeals.

As the court of appeals explained (Pet. App. 7-8), 42 C.F.R. 489.18(d) explicitly provides that an assigned provider agreement "is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued." Those terms and conditions include provider liability for overpayments of the sort at issue here, which arise from the fact that Medicare is required by statute to make periodic payments on an estimated basis during each fiscal year, subject to a year-end accounting on the basis of actual experience and either a final payment or recoupment of any overpayment by Medicare. See Pet. App. 8; 42 U.S.C. 1395g(a), 1395x(v)(1)(a)(ii); *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. 2151 (1993). The decision in this case to seek recoupment from petitioner as the assignee of the provider agreement under which the overpayment in question was made involved no new "interpretive rulemaking" (Pet. 15), but merely application to particular facts of an explicit regulatory requirement.

Petitioner's arguments about the new "interpretive rule" purportedly applied here—that it has been

improperly given retroactive effect (Pet. 17-20); that it violates due process, the Administrative Procedure Act, 5 U.S.C. 551 *et seq.*, and principles of equity because it was not published before implementation (Pet. 20-24); and that it should be more carefully scrutinized when, as here, it preempts state law (Pet. 26-29)—are therefore simply inapposite. This case involves no rule or regulation other than Section 489.18(d), which has been in force since 1980 (see Pet. 18 n.4); and the decision in this particular case rested not on deference to the Secretary's interpretation of that rule, but on the court of appeals' own "*de novo*" review. See Pet. App. 6. Cf. *John Hancock Mut. Life Ins. Co.* v. *Harris Trust & Sav. Bank*, 114 S. Ct. 517, 531 (1993) (noting issue of deference to agency interpretations expressed in litigation).[1]

2. Petitioner challenges (Pet. 17 n.3; see also Pet. 20-24) the court of appeals' holding that Section 489.18(d), and the other statutory and regulatory provisions that it incorporates by reference, impose liability for previous overpayments on successor providers like petitioner. As the court explained (Pet. App. 7-9), however, that result follows logically not only from the language of the

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[1] For the same reason, there is no substance to petitioner's assertion (Pet. 19-20) that the decision below conflicts with the decision in *Health Ins. Ass'n of America* v. *Shalala*, 23 F.3d 412, 422-425 (D.C. Cir. 1994). In *HIAA*, the court indicated that in determining what degree of deference to accord to an agency interpretation embodied in a formal interpretive rule, the court would distinguish between transactions undertaken before and after adoption of the rule. See 23 F.3d at 422, 425. In this case, the court of appeals relied on 42 C.F.R. 489.18(d) and other applicable statutory and regulatory provisions, rather than on any new interpretive rule. There is no dispute that Section 489.18(d) applies to petitioner's acquisition of Vernon I and its succession to Vernon I's provider agreement.

relevant provisions, but from the structure of the Medicare program.

As noted above and by the court of appeals (Pet. App. 8), Medicare relies on a system of interim estimated payments made subject to a final, year-end accounting. That system insures liquidity for providers, as well as uninterrupted service for beneficiaries. Thus, when a new owner acquires the assets of an existing provider and chooses to accept assignment of that provider's reimbursement agreement with Medicare, it should not come as a surprise that the new provider succeeds not only to the seller's rights under that agreement, but also to its obligations—including repayment obligations that may arise out of the routine year-end process of reconciling estimated payments with the provider's actual experience. Petitioner cites no decision that has come to a contrary conclusion, and the matter does not warrant further review.[2]

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[2] If, in fact, petitioner did not recognize its potential successor liability for the overpayments at issue here—about which, as petitioner itself notes (Pet. 13), the Secretary had already notified Vernon I well before the acquisition—then it may have accepted that liability "unknowingly." Pet. App. 9. But even if petitioner failed to appreciate the full legal consequences of its assumption of the provider agreement, or to protect itself contractually against unanticipated liabilities, the result in this case is neither unforeseeable nor unfair. Moreover, as the court of appeals pointed out (*id.* at 8), petitioner could have declined automatic assignment of Vernon I's provider agreement and entered into a new and separate agreement directly with the Secretary, thereby avoiding any possible responsibility for prior overpayments.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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